Halton Healthcare	Critical Incident Policy			
	Program/Dept:	Quality & Patient Relations	Document Category:	Quality and Patient Relations
	Developed by:	Director for Quality & Patient Relations, Quality Council, MAC	Original Approval Date:	December 2009
	Approved by:	Quality Council	Reviewed Date:	February 2015
	Review Frequency:	3 years	Revised Date:	January 2018

Purpose

Halton Healthcare is committed to patient safety and continuous quality improvement. The effective management of safety incidents is an important part of this corporate commitment. The purpose of this policy is to provide specific direction to those hospital personnel responsible for and/or involved in the determination, reporting and tracking of serious safety incidents which have been determined to have met the definition of Critical Incident (CI) per Regulation 965, Public Hospitals Act.

Requirement under the PHA -

- Hospital Board must ensure that administrator provides aggregated CI data related to critical incidents occurring at the hospital to the hospital's Quality Committee at least twice per year
- Aggregated data shall include data about all critical incidents since the previous report of aggregated critical incidents to the Quality Committee

Scope

This policy applies to all physicians, and staff of Halton Healthcare who have responsibility for oversight of critical incident management.

Definitions

Safety Incident: An unexpected event or circumstance that could have resulted, or did result in unnecessary harm to a patient/person, loss or damage.

Critical Incident: A critical incident is an unintended event that occurs when a patient receives treatment in the hospital that results in death, or serious disability, injury or harm to the patient, and does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing treatment. Reference*: Regulation 965, Public Hospitals Act*.

Policy

1. For all Actual or Potential Patient Safety Incidents please refer to the Incident Management Policy and Procedure.
2. For **serious** incidents (harm levels 4-5), staff must immediately notify by phone or pager the MRP, direct supervisor and Manager/Manager-on-call or delegate who then notifies the Director. The Program/Department Director then notifies the following individuals:
    - Appropriate Chief Operating Office / Vice President
    - Chief , Co-Chief, Associate Chief of Staff / Department Chief
    - Most Responsible physician (MRP)
    - VP Clinical Programs and CNO
    - Director Quality and Patient Relations
    - Others as required e.g. Professional Practice Leaders, Security Services, Public Relations

(Note that once a *serious* incident is submitted in the IRS, the system triggers automatic email notification to the senior leadership team)

3. Disclosure to the patient and Substitute Decision Maker (SDM) occurs in accordance with the Disclosure Policy.
4. The Program Director and Director of Quality and Patient Relations will lead a Critical Incident Triage Meeting to determine the status of the incident. (See Appendix A - *Critical Incident Determination tool*).
5. All incidents, regardless of the "Critical" determination will continue through the incident management process described in the Incident Management Policy & Procedure. This includes initiation of an immediate follow-up investigation and fact finding, including an offer to interview the patient or their authorized representative [1]. A Quality of Care review is conducted with participation of the Patient Relations Advisor or designate who can provide the patient perspective during the review.
6. The Quality of Care Committee will coordinate disclosure to the Medical Advisory Committee (MAC) utilizing the Regulatory Notification Template of Potential Critical Incidents (refer to Appendix B)
7. The Quality of Care Committee will prepare a summary of aggregate critical Incident data to the Quality and Risk Management Committee of the board at least twice a year.
8. All critical incidents related to **medication / IV fluids** shall be reported through the National System of Incident Reporting (NSIR) within 30 days following the disclosure of the critical incident to the Medical Advisory Committee (MAC), administrator and/or patient.
9. The board is required to ensure the hospital has a process in place analyze the incident and develop a plan with the systemic steps to avoid or reduce the risk of further similar critical incidents.
10. A Status Report on recommendations will be reviewed at Quality Council within three months, as submitted through the Director, Quality and Patient Relations.

Roles/Responsibilities

Defined within the policy

Related Documents

Disclosure of Safety Incidents
Incident Management Policy & Procedure

Key Words

Safety Incident, Incident Management, Critical Incident, Critical, Harm, Disclosure, Serious incident, Serious, Adverse event

Reviewed by/Consultation

Quality Council, MAC

Signed by _____

Title _____

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Appendices

Appendix A - Critical Incident Determination tool
Appendix B - Regulatory Notification Template of Potential Critical Incidents

Appendix A

Critical Incident Determination Tool

Privileged and Confidential: Prepared for Quality of Care Purposes

The Emergency Teleconference/Meeting should be held as soon as possible (within one business day) following the potential critical incident. The COO of the applicable program is required to coordinate the teleconference.

DEFINITION: As defined under the *Public Hospitals Act* , a Critical Incident (CI) is "an unintended event that occurs when a patient receives treatment in the hospital; that results in death, or serious disability, injury or harm to the patient, and does not result primarily from the patient 's underlying medical condition or from a known risk inherent in providing treatment ".

Date of Potential Critical Incident: _____Date of Teleconference/Meeting: _____

IRS#: _____

Participants to Include:

☐ COO(s) of involved area(s) __ _____ ☐ Dir Quality & PR _____

☐ Manager/Supervisor of Areas: _____

☐ Program Director(s) of involved area(s) _____

☐ Medical Director/Chief/Designate___ _____

☐ Chief of Staff _____

☐ Senior VP Clinical Programs _____

☐Others as required _____

Agenda of Teleconference/Meeting: *(check as completed)*

☐ Review of the details of the incident

To determine if this is a "Critical Incident " as defined above, the following questions must be answered:

1) Did something unintended happen to the patient? ☐ Yes ☐ No
2) Was the patient under the care of the facility at the time? ☐ Yes ☐ No
3) Was there disability, injury or harm? If so what harm level? ☐ Yes ☐ No
4) Are there consequences to the patient now or in the future? ☐ Yes ☐ No
5) Did the incident result primarily from the patient's underlying medical condition? ☐ Yes ☐ No
6) Did the incident result from a known risk inherent in providing the treatment? ☐ Yes ☐ No
7) Were all reasonably available preventable measures in place at the time of the incident? If yes, were they adhered to? ☐ Yes ☐ No

If the answer to # 5, 6, 7 'YES', this incident would NOT be a "Critical Incident".

Determination of Critical Incident ☐ Yes ☐ No

☐ Discuss immediate containment options if appropriate.

☐ Confirm COO lead for Critical Incident

_____

☐ Confirm initial disclosure has occurred ☐ Yes ☐ No (see Disclosure Policy for entire Disclosure process)

❖ Consider timing of disclosure, status of patient, presence of patient supports, most appropriate person to disclose.

☐ Assign lead for communication with patient/POA/Legal SDM

Communication Lead: _____

☐ Are there concerns related to individual performance or a history of performance concerns?

If yes, performance concerns need to be reviewed separately.

☐ Establish review method:

- ☐ Program Quality of Care Review (not QCIPA)
- ☐ Program Quality of Care Review (QCIPA)
- ☐ Performance Review (to be conducted by manager or appropriate chief)

☐ Is it recommended this review be conducted under QCIPA? - If Yes, Quality & Patient Relations will forward request to Chair of designated Quality of Care Committee or delegate

☐ Determine participants for review meeting *(discuss who needs to be involved, maximum 10-12 participants)*-

☐ Determine lead responsible for:

- ☐ Documentation of sequence of events (chronology (name) _____
- ☐ Reporting incident in IRS database (name) _____
- ☐ Initial steps of investigation (which may include):
  - Patient/family interview
  - Staff interviews
  - Chart review
  - Policy/procedure review

☐ If medication/IV fluid administration incident, then discuss reporting to the National System of Incident Reporting (NSIR) (required to be done within 30 days following disclosure of the CI to MAC, CEO and/or patient).

☐ Yes ☐ No

☐ Quality & Patient Relations with approval of COO lead to complete template for Mandatory CI Notification to CEO/Chair of MAC.

Levels of Harm	Examples
Level 0 – Near Miss An incident which did not reach the patient. If the near miss had the potential for severe outcome, contact Risk Management to discuss.	1. Incorrect drug or correct drug at incorrect rate or volume discovered before administration to the patient 2. Defibrillator found to be uncharged or non-functioning during a routine or random check 3. Lab bag labeled incorrectly but discovered before item erroneously sent out.
Level 1 – No Harm Incident An incident in which an event reached a patient but no discernible harm resulted.	1. Medication error not resulting in injury or harm 2. Slip/falls that resulted in no injury
Level 2 – Harmful Incident – Mild Harm Patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate but short term, and no/minimum intervention is required.	1. Diabetic patient given wrong diet, increased blood sugar which required monitoring 2. Defibrillator pads improperly applied, causes minor skin irritation 3. Fall, minor laceration
Level 3 – Harmful Incident – Moderate Harm Patient outcome is symptomatic, requiring intervention an increased length of stay, or causing permanent or long term harm or loss of function.	1. Incorrect medication given requiring cardiac monitoring 2. Fall, fractured arm requiring casting, no surgery
Level 4 – Harmful Incident – Severe Harm Patient outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention, shortening life expectancy or causing major permanent or long-term harm or loss of function.	1. Correct medication at incorrect rate or volume resulting in resuscitation or other life-saving measure 2. Major fractures (hip, skull) requiring surgery 3. Surgery/Procedure error i.e. wrong site, wrong patient or wrong procedure 4. Unsuccessful Code Blue
Level 5 – Harmful Incident – Death On balance of probabilities; Death was caused or brought forward in the short term by the incident.	1. Successful on-site suicide 2. Death as a result of a fall 3. Maternal/infant death associated with labour or delivery 4. Ventilator loses power resulting in death 5. Unsuccessful Code Blue

Appendix B

Regulatory Notification Template of Potential Critical Incidents

Privileged and Confidential: Prepared for Quality of Care Purposes

Disclosure of Critical Incident Disclosure to MAC (Per Public Hospitals Act, Reg 965)

Critical Incident Definition

A "critical incident" is defined as any unintended event that occurs when a patient receives treatment in the hospital that::

a) Results in death, or serious disability, injury or harm to the patient; and

b) Does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing treatment.

Reference: An Ontario Guide to Disclosure: Implementing the Amendments to Regulation 965 under the Public Hospitals Act

Date of Report to MAC : _____

Incident #	**Incident Date**	**Program Service**	**Incident Summary (*Material Facts Only*)**	**Consequences for patient**	**Actions taken & Recommendations**	**QCIPA Review (Y/N)**